# Filing at a Glance

| | |
|---|---|
| Company: | Boston Mutual Life Insurance Company |
| Product Name: | General Agency Simplified Underwriting Application |
| State: | Arkansas |
| TOI: | L07I Individual Life - Whole |
| Sub-TOI: | L07I.101 Fixed/Indeterminate Premium - Single Life |
| Filing Type: | Form |
| Date Submitted: | 10/17/2012 |
| SERFF Tr Num: | BSTN-128730545 |
| SERFF Status: | Closed-Approved-Closed |
| State Tr Num: | |
| State Status: | Approved-Closed |
| Co Tr Num: | IND-12-009 |
| Implementation Date Requested: | |
| Author(s): | Peggy Schwartz, Kathy Padis |
| Reviewer(s): | Linda Bird (primary) |
| Disposition Date: | 10/23/2012 |
| Disposition Status: | Approved-Closed |
| Implementation Date: | |

State Filing Description:

**State:** Arkansas **Filing Company:** Boston Mutual Life Insurance Company
**TOI/Sub-TOI:** L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life
**Product Name:** General Agency Simplified Underwriting Application
**Project Name/Number:** GA SI Underwriting Application /IND-12-009

## General Information

Project Name: GA SI Underwriting Application
Project Number: IND-12-009
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Kathy Padis

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filed Concurrently.
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/23/2012
State Status Changed: 10/23/2012
Created By: Kathy Padis
Corresponding Filing Tracking Number: IND-12-009

Filing Description:

RE: Boston Mutual Life Insurance Company
NAIC # 61476 FEIN #04-1106240
Individual Life Insurance Application Form:
Form #: SF/SD 3/12

Company Filing No. IND-12-009

We are submitting for approval the above application form. This is a new form and does not replace any existing form.

This is a simplified underwriting application which will be used by licensed independent agents and brokers in the individual life insurance market. It will be used to apply for both whole life and term life coverage under policy forms approved in your state.

The form does not contain any unusual or controversial items from the standpoint of normal company or industry standards. The form is in final print, 10-point type. It meets the minimum readability requirements of this state and a certification is included with this filing. To the best of our knowledge and belief, this submittal complies with the laws and regulations of your state.

DOMICILLIARY APPROVAL: This form was filed concurrently in Massachusetts our state of domicile.

## Company and Contact

### Filing Contact Information

Peggy Schwartz, Product Filing Manager
120 Royall Street
Canton, MA 02021

marguerite_schwartz@bostonmutual.com
781-770-0423 [Phone]
781-770-0490 [FAX]

### Filing Company Information

Boston Mutual Life Insurance Company
120 Royall Street
Canton, MA 02021
(781) 770-0423 ext. [Phone]

CoCode: 61476
Group Code: 581
Group Name:
FEIN Number: 04-1106240

State of Domicile: Massachusetts
Company Type:
State ID Number:

***State:*** *Arkansas* ***Filing Company:*** *Boston Mutual Life Insurance Company*
***TOI/Sub-TOI:*** *L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life*
***Product Name:*** *General Agency Simplified Underwriting Application*
***Project Name/Number:*** *GA SI Underwriting Application /IND-12-009*

## Filing Fees

Fee Required? Yes
Fee Amount: $225.00
Retaliatory? Yes
Fee Explanation: Massachusetts would charge $225.00 for this Filing so the fee is $225.00.
Per Company: No

| Company | Amount | Date Processed | Transaction # |
|---|---|---|---|
| Boston Mutual Life Insurance Company | $225.00 | 10/17/2012 | 63976555 |

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|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *BSTN-128730545* | ***State Tracking #:*** | | ***Company Tracking #:*** | *IND-12-009* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Boston Mutual Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life* | | |
| ***Product Name:*** | *General Agency Simplified Underwriting Application* | | |
| ***Project Name/Number:*** | *GA SI Underwriting Application /IND-12-009* | | |

# Correspondence Summary

## Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Linda Bird | 10/23/2012 | 10/23/2012 |

## Amendments

| Schedule | Schedule Item Name | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| Supporting Document | Statement of Variability | Peggy Schwartz | 10/19/2012 | 10/19/2012 |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *BSTN-128730545* | ***State Tracking #:*** | | ***Company Tracking #:*** | *IND-12-009* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Boston Mutual Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life* | | |
| ***Product Name:*** | *General Agency Simplified Underwriting Application* | | |
| ***Project Name/Number:*** | *GA SI Underwriting Application /IND-12-009* | | |

## Disposition

Disposition Date: 10/23/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | | Yes |
| **Supporting Document** | Application | | No |
| **Supporting Document** | Life & Annuity - Acturial Memo | | No |
| **Supporting Document** | Cover Letter | | Yes |
| **Supporting Document** | Statement of Variability | | Yes |
| **Form** | General Agency Simplified Underwriting Application | | Yes |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *BSTN-128730545* | ***State Tracking #:*** | | ***Company Tracking #:*** | *IND-12-009* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Boston Mutual Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life* | | |
| ***Product Name:*** | *General Agency Simplified Underwriting Application* | | |
| ***Project Name/Number:*** | *GA SI Underwriting Application /IND-12-009* | | |

# Amendment Letter

Submitted Date: 10/19/2012

Comments:

Added Statement of Variability - The statement of variablilty was inadvertently dropped from this filing. It has now been added back in. Thank you for your patience.

Changed Items:

**Supporting Document Schedule Item Changes:**

User Added -Name: Statement of Variability

Comment:

statement of variability LIFE.pdf

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *BSTN-128730545* | ***State Tracking #:*** | | ***Company Tracking #:*** | *IND-12-009* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Boston Mutual Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life* | | |
| ***Product Name:*** | *General Agency Simplified Underwriting Application* | | |
| ***Project Name/Number:*** | *GA SI Underwriting Application /IND-12-009* | | |

# Form Schedule

**Lead Form Number: SF/SD 3/12**

| Item No. | Schedule Item Status | Form Number | Form Type | Form Name | Action/ Action Specific Data | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|
| 1 | | SF/SD 3/12 | AEF | General Agency Simplified Underwriting Application | Initial: | 68.200 | 914-081 Stnd SF-SD app.pdf |

**Form Type Legend:**

| | | | |
|---|---|---|---|
| **ADV** | Advertising | **AEF** | Application/Enrollment Form |
| **CER** | Certificate | **CERA** | Certificate Amendment, Insert Page, Endorsement or Rider |
| **DDP** | Data/Declaration Pages | **FND** | Funding Agreement (Annuity, Individual and Group) |
| **MTX** | Matrix | **NOC** | Notice of Coverage |
| **OTH** | Other | **OUT** | Outline of Coverage |
| **PJK** | Policy Jacket | **POL** | Policy/Contract/Fraternal Certificate |
| **POLA** | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | **SCH** | Schedule Pages |

# BOSTON MUTUAL LIFE INSURANCE COMPANY

**APPLICATION FOR INDIVIDUAL LIFE INSURANCE - COMBINED SF/SD**

**120 ROYALL STREET · CANTON, MASSACHUSETTS 02021-9968**
**NEW BUSINESS FAX: 877-366-3036 OR 781-770-0441**

| | 1st AGENT | 2nd AGENT |
|---|---|---|
| Agency # | | |
| Payroll # | | |

**1. Primary Proposed Insured** *(Last, First, MI)* | Maiden Name | Sex ☐M ☐F | Date of Birth *Month Day Year* | Age | Place of Birth

Residence Address of Primary Proposed Insured: No. & Street | City | State | Zip

Communications Address *(if other than residence address):* No. & Street | City | State | Zip

Telephone Numbers — Day: | Evening: | Cell: | Time to Call | E-Mail

Social Security # / TIN # ___ – ___ – ____ | Occupation | Monthly Income $ | Marital Status ☐married ☐single | Height & Weight ___ ft. ___ in.-_____ lbs.

Name & Address of Primary Proposed Insured's Employer: No. & Street | City | State | Zip

Is the Primary Insured actively at work? *(at least 30 hours per week)* ☐ Yes ☐ No If No, please explain:

| **Plan for all Proposed Insureds** | Primary Insured's Amt. $ | Premium Amt. $ | Accidental Death Benefit (ADB) ☐ Yes ☐ No - Amt.$ | Waiver of Premium ☐ Yes ☐ No | APL ☐ Yes ☐ No |
|---|---|---|---|---|---|

| **Primary Beneficiary(ies) for Primary Proposed Insured** | **Address & Telephone Number** | **Relationship to Primary Insured** | **% of Share** | **Age** | **Date of Birth** | **Date of Trust** |
|---|---|---|---|---|---|---|
| **1.** | | | | | | |
| Social Security # / TIN # | | | | | | |
| **Primary Beneficiary(ies) for Primary Proposed Insured** | **Address & Telephone Number** | | | | | |
| **2.** | | | | | | |
| Social Security # / TIN # | | | | | | |

| **Contingent Beneficiary(ies) for Primary Proposed Insured** | **Address & Telephone Number** | **Relationship to Primary Insured** | **% of Share** | **Age** | **Date of Birth** | **Date of Trust** |
|---|---|---|---|---|---|---|
| **1.** | | | | | | |
| Social Security # / TIN # | | | | | | |
| **Contingent Beneficiary(ies) for Primary Proposed Insured** | **Address & Telephone Number** | | | | | |
| **2.** | | | | | | |
| Social Security # / TIN # | | | | | | |

**2. Name of Additional Proposed Insured** | Relationship to Owner | Sex ☐M ☐F | Date of Birth *Month Day Year* | Age | APL ☐ Yes ☐ No

Place of Birth | Social Security # / TIN # ___ – ___ – ____ | Height & Weight _____ ft. _____ in. _____ lbs. | Marital Status ☐ Married ☐ Single

Amt. of Insurance $ | Premium Amt. $ | Beneficiary Name, Address and Tele.# | Social Security # / TIN # | Age | Date of Birth *Month Day Year* | Relationship

WP ☐Y ☐N | ADB ☐Y ☐N - Amt. $ | Employer & Address | Occupation | Monthly Income $ | Actively at Work ☐ Yes ☐ No

Additional Insured Address if different from Owner: | Telephone Numbers Home: | Other:

**3. Owner** *(Complete if other than Primary Proposed Insured)* | Relationship | Owner SS # / TIN # ___ – ___ – ____ | Owner Phone #

Name: | Owner's Date of Birth

Residence Address:

**4. Payor** *(if other than Primary Proposed Insured)* | Relationship | Payor's SS # / TIN # ___ – ___ – ____ | Payor's Phone #

Name: | Payor's Date of Birth

Residence Address:

Payor's Employer & Address: City | State | Zip | Monthly Income $ | Payor's Occupation | Height & Weight *(if covered)* ___ ft. ___ in.-_____ lbs.

**Mode of Payment:** ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ PAC ☐ Allotment * ☐ Salary Deduction *

Total Premium paid with application $_____ * Frequency of deduction: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

Total Modal Premium $_____ + PDF Amount $_____ = Total $_____

**5. Supplementary Benefits and Riders - verify availability.**

**Primary Proposed Insured, Children:**

| *Rider* | *Duration* | *Amount* |
|---|---|---|
| ☐ Children's Insurance Agreement | | $_____ |
| ☐ X-P Term Rider | _____ yrs. | $_____ |
| ☐ Disability Income | 6 yrs. | $_____ per mo. |
| ☐ GIR | | $_____ |
| ☐ Other_____ | | |

**Payor/Second Insured Rider Only:**

| *Rider* | *Duration* | *Amount* |
|---|---|---|
| ☐ Payor Benefit *(complete employment, ht. &wt. &medical questions)* | | Payor Height & Weight __ft. ___in. -____lbs. |
| ☐ X-P Term Rider | _____ yrs. | $_____ |
| ☐ Other_____ | | |

**DIVIDEND OPTIONS IF APPLICABLE. Dividends available for participating products only (example: OL)**

**Dividend Options:** ☐ Paid-Up Additions ☐ Accumulative at Interest ☐ Cash ☐ Reduced Premium ☐ One Year Term

**6. List Dependent Children only if CIA Rider coverage is requested.**

**To be covered children must be** *(the Insured's natural children, legally adopted or step-children. If not living with Proposed Insured, please explain)*

| **Name** *(Last, First, MI)* | **Sex** | **Relationship to Primary Insured** | **Date of Birth** | **Height & Weight** | **Age** |
|---|---|---|---|---|---|
| | ☐ M ☐ F | Child | | - | |
| | ☐ M ☐ F | Child | | - | |
| | ☐ M ☐ F | Child | | - | |
| | ☐ M ☐ F | Child | | - | |

**7. Information on Existing Insurance**

| | **Primary Insured** | **Spouse or Other Insureds** | **Children** |
|---|---|---|---|
| A. Do you have any existing life insurance or annuity contracts in force or pending? ***If "Yes" submit form NB-47 (Std-A) and list existing insurance below.*** | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| B. Will any policy applied for replace or change any existing life insurance or annuities on the life of any proposed covered person? ***If "Yes" submit all required replacement forms.*** | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

| **List all existing or pending insurance:** *Insured Name, Company Name and Address* | **Type** | **Amount** | **ADB Amount** | **Date Issued** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**8. SIMPLIFIED ISSUE QUESTIONS** ***(Please refer to height & weight chart and age & amount guidelines)***

| | **Primary** | **Spouse ONLY** | **Children Rider ONLY** |
|---|---|---|---|
| **1.** Have you used any form of tobacco or nicotine products in the past 12 months?. . . . . | ☐ YES ☐ NO | ☐ YES ☐ NO | |
| **2.** Are you a U.S. citizen? If anyone to be insured is **NOT** a U.S. citizen provide details: . . . . | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| **3.** Are there any existing life insurance policies or annuity contracts currently in force or pending?. . | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| a. How much insurance do you have in force or pending?_____ | | | |
| b. Will the policy applied for replace or change any insurance or annuities? If yes, submit any necessary replacement forms and give policy number, name and address of company. | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| **4.** Are you actively at work as of this date? . . . . . | ☐ YES ☐ NO | ☐ YES ☐ NO | |
| **5.** Have you missed three or more consecutive days of work *(for children: school)* or normal activity due to illness or injury during the last 120 days? . . . . . | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| **6.** Have you within the past 10 years been diagnosed or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); or tested positive for antibodies to the AIDS virus *(Human Immunodeficiency Virus)*? . . . . . | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| **7.** Have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: Heart attack; Heart Bypass; Coronary Artery Disease; Congestive Heart Failure; Stroke; Cancer *(other than Basal Skin Cancer)*; Chronic Obstructive Lung Disorder; COPD; Emphysema; Liver Disease; Kidney Failure; or Organ Transplant? . . . . . | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |
| **8.** Have you been hospitalized in the last 90 days or been advised by a member of the medical profession to seek: medical advice; treatment; care and/or counseling that has not yet been performed? . . . . . | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

**If questions 5, 6, 7, and 8 are answered "YES" and/or question 4 is answered "NO" in Section 8, the proposed insured does not qualify for Simplified Issue, and the medical questions as well as any applicable sections on the following pages must be completed.**

## – NON-SIMPLIFIED ISSUE QUESTIONS –

**Complete these questions if insured does not qualify for Simplified Issue. Explain any "yes" answers in Section 10 below:**

**9A.** Licensed health care provider includes, but is not limited to, physicians, chiropractors, physical therapists, psychologists, and drug and alcohol, or mental health counselors. Medical facility includes hospital, clinic, mental health facility, and drug or alcohol treatment or consultation facility.

| **Has ANY person to be insured:** | **Primary Insured** | **Other Insureds and or Payor if covered** | **Children** |
|---|---|---|---|
| A. Used any form of tobacco or nicotine product in the past 12 months? | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| B. Ever used any form of tobacco or nicotine product in the past? If "YES" type and date ceased. _____ | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| C. Within the past **5 years** consulted with *(including doctor's visits)*, received treatment from, been advised to receive treatment from a licensed health care provider or medical facility for any reason? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| D. Ever had, been diagnosed or treated by a licensed health care professional for: Cancer; tumors or other malignancy; kidney disease; liver disease; diabetes or urinary tract impairment; lung disease; high blood pressure; stroke; mental disorder; seizure; nervous system disorder; heart or circulatory disease or disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| E. Used or are currently using or ever received treatment or were diagnosed for alcoholism or for the use of heroin, morphine, other narcotics, marijuana, barbituates, amphetamines or hallucinogenic drugs? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| F. Have you within the past 10 years been diagnosed or treated by a member of the medical profession for Aquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for antibodies to the AIDS virus *(Human Immunodeficiency Virus)?* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| G. Within the next 2 years, any intention to travel or to reside outside the United States or Canada? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| H. Been convicted, on probation or awaiting trial for a felony? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| I. Within the past 5 years: had a driver's license suspended or revoked; or been convicted of a moving traffic violation? **Driver's License #** _____ **State** _____ | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| J. Engaged in or plan to engage in the following activities: aviation; hang gliding; parasailing; racing (any type); rodeo; competitive skiing; scuba; or skydiving? If "Yes", circle activity and submit **form NB-AV-Q or form NB-HA-Q.** | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| K. Ever been declined, postponed, rated or charged an extra premium for health, life or critical illness insurance; been offered a policy different from that applied for; or been refused reinstatement or renewal of life or health insurance? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **9B.** Are you a U.S. citizen? **If anyone to be insured is NOT a U.S. citizen provide details:** _____ | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

**10. Give complete details in the space below of any "Yes" answers recorded in this application. If more space is needed, attach a signed supplement to the application.** ***(Check Box ☐ if supplement is used)***

| Details to "Yes" Answers | | Illness, operation or other cause. Reason for any check-up, doctor's advice treatment and medication *(list all medications currently taken)* | Diagnosis Dates and Duration | Names, Telephone #'s, Addresses of Doctors and Hospitals |
|---|---|---|---|---|
| Question# | Name of Proposed Insured | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**11. FAMILY HISTORY OF INDIVIDUALS APPLYING FOR INSURANCE:**

Have the biological parents, brothers, sisters, either living or deceased, of individuals applying for insurance been treated for or diagnosed with any of the following: diabetes; cancer; high blood pressure; stroke; heart disease; kidney disease or Huntington's Chorea? ☐ **Yes** ☐ **No**

***If "Yes", provide details below.***

| **Relative** | **Name of Insured** | **Condition** | **Age at Onset** | **Age if Living** | **Age at Death** |
|---|---|---|---|---|---|
| Mother | | | | | |
| Father | | | | | |
| Siblings | | | | | |
| | | | | | |

## – ACKNOWLEDGEMENTS –

To the best of my knowledge and belief, the statements in this application are complete and true. It is understood that if any statement is a material misrepresentation, coverage may be contested as a result. This application and any supplement shall form the basis for and become part of any policy issued. When the Company gives a Conditional Receipt coverage will start as shown in that form, provided the Company approves the application without any modification as to plan, amount or premium. If the application is approved with any such modification, the insurance will not take effect until the policy has been delivered to and accepted by me and will not take effect if there has been a change in my health as stated in the application.

**The agent or tele-inteviewer has no authority to waive the answer to any question in or to modify the application.**

**Corrections and Amendments to be Accepted by Owner on Delivery of Contract.**

## CONSUMER REPORT AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

## MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formally known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

## MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

## BOSTON MUTUAL LIFE INSURANCE COMPANY
## AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION

***(This authorization complies with the HIPAA Privacy Rule)***

I authorize any health plan, insurer, physician, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, services, or payment to the Proposed Insured/s, or on their behalf, as well as the MIB, Inc. *(formally known as the Medical Information Bureau, Inc.)* and other medical information providers, to disclose the entire medical record and any other Protected Health Information concerning such person to the Boston Mutual Life Insurance Company (BML), its employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. The Protected Health Information is being disclosed so that BML may: 1) underwrite/assess an applicant's eligibility for coverage, 2) obtain reinsurance, 3) pay claims and, 4) conduct other legally permissible activities related to the coverage applied for by this individual. This authorization shall remain inforce for 24 months following the date of my signature below. A copy of this authorization is as valid as the original. I understand that: I or my authorized representative have the right to revoke this authorization at any time by sending a written request for revocation. Revoking or failing to sign this Authorization may impair BML's ability to process this application; a revocation is not effective to the extent that the Authorization has been relied on for the above listed uses; any information disclosed pursuant to this authorization may be redisclosed and redisclosed information may no longer be covered by federal rules governing privacy or health information. I acknowledge that I have received a copy of BML's Notice of Privacy Practices. I have read this Authorization and understand that I or my authorized representative can receive a copy of it.

## • DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, hereby, designate the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative. This designation shall remain inforce for a period of 12 months following my date of death.

**"Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law."**

**NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.**

**NOTE: The agent is required to leave with you an original copy of written or printed communications used for presentation of the policy to you.**

| | |
|---|---|
| | |
| **Application Signed at *(City, State)*** | **Signature of Primary Proposed Insured *(Parent or Guardian must sign if proposed insured is under age 15)*** |

| | | |
|---|---|---|
| | | |
| **Date of Application** | **Signature of Other Proposed/Spouse Insured** | **Signature of Owner if other than Primary Proposed Insured, Parent or Guardian** |

| |
|---|
| |
| **Name, Address and Telephone # of Secondary Addressee** |

**– FOR ANY ADDITIONAL PROPOSED INSUREDS, SEE ADDENDUM PAGE –**

## FINANCIAL QUESTIONS

**Complete when applying for the total amount of insurance $200,000 and over on any insured.**
*(Please submit copies of financial statements, estate analysis, contractual agreements, etc. if used during the sale.)*

**What is the purpose of this insurance?** _____
*(e.g. estate conservation, buy-sell, keyperson)*

How was the need for the Face Amount determined? _____

| | Primary Insured | Other Insured |
|---|---|---|
| Gross annual earned income (salary, commissions, bonuses, etc.) | $ | $ |
| Gross annual unearned income (dividends, interest, net real estate income, etc.) | $ | $ |
| Household net worth (combined) | $ | |

In the last 5 years, has/have either of the Proposed Life Insured(s), or the business had any major financial problems (bankruptcy, etc.)? ☐ **Yes** ☐ **No** ***If "Yes", give details*** _____

Additional Comments:

**Bank Draft Plan**

☐ **Checking**
Attach VOIDED check

☐ **Savings**
Transit/Routing and Account # Required

**And sign Authorization to the right**

### REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN

**Bank Name** _____ **Bank Tel.#** _____

**Transit/Routing #** _____ **Account #** _____

I authorize the payment of debits drawn on my account payable to Boston Mutual Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in the forfeiture of insurance. This authority shall remain in effect until revoked by me in writing and until you actually receive such notice of revocation.

I request withdrawal of payment on the ☐ **1st** ☐ **5th** ☐ **10th** ☐ **15th** ☐ **20th or** * ☐ **25th** day of each month beginning in the month of _____ ** (automatic option if no date is chosen)*

| **Date** | **Signature** ***(as it appears on bank records)*** |
|---|---|
| | **Signature of Joint Account Holder** ***(if applicable)*** |

Comments or Special Requests: _____

## AGENT'S REPORT AND CERTIFICATION: *(Must be completed in all cases)*

A. Agent relationship to proposed insured(s)? ☐ Met on solicitation ☐ Friend ☐ Relative _____
How long have you known the proposed insured(s)? _____

B. What are the client's Insurance objectives? ☐ Mortgage ☐ Final Expense ☐ Business ☐ Family Protection ☐ Other: _____

C. If Proposed Insured(s) is a dependent, amount of insurance on Parents or Legal Guardian: $ _____
Are all siblings equally insured? If no, provide details: _____ ☐ Yes ☐ No

| | | |
|---|---|---|
| D. | Did you, with the client's assistance, determine the insurance needs/suitability? | ☐ Yes ☐ No |
| E. | Did you see all of those to be insured on the date the application was written and signed? | ☐ Yes ☐ No |
| F. | Do they all reside within the same home? | ☐ Yes ☐ No |
| G. | Did you witness the signing of the application? | ☐ Yes ☐ No |
| H. | Were the questions contained in this Application asked *(as printed)* of the Proposed Insured(s), Owner(s) and the answers correctly recorded? | ☐ Yes ☐ No |
| I. | Did you review an unexpired government issued picture ID sufficient to verify the identity of the Proposed Owner(s)? | ☐ Yes ☐ No |
| J. | Did the Proposed Owner/Applicant and Proposed Insured(s) exhibit any suspicious behavior that could be related to money laundering activities while completing this application? | ☐ Yes ☐ No |
| K. | Was the policy sold using a premium payment plan in which all or part of the future premiums are to be paid with values from loans, dividends or cash surrenders? | ☐ Yes ☐ No |
| L. | To the best of your knowledge and belief, is any life insurance or annuity in force in this or any other company to be replaced in whole or in part by this insurance? | ☐ Yes ☐ No |

**Certification –**
I certify: (1) that this Application and any accompanying information are complete and true to the best of my knowledge and belief; and that I have given the Proposed Insured(s)/Owner the Notice of Information Privacy Practices; (2) that to the best of my knowledge and belief, the purchase of this insurance coverage will not result in a "stranger originated life Insurance policy" or STOLI transaction.

| **Agent's Signature** | **Print Agent's Name** | **Agent's Phone Number** | **Agent's NPN** |
|---|---|---|---|
| | | | |

**Boston Mutual Life Insurance Company does not accept checks with policies for $500,000.00 and over.**
**Please Enclose a Signed Illustration for Plans and States where required.**

## APPLICATION SUPPLEMENT

### ADDITIONAL BENEFICIARY INFORMATION

| Primary Beneficiary: Name | Address & Telephone Number | Social Security #/TIN # | Relationship to Primary Insured | % of Share | Age | Date of Birth | Date of Trust |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| **Contingent Beneficiary: Name** | **Address & Telephone Number** | **Social Security #/TIN #** | **Relationship to Primary Insured** | **% of Share** | **Age** | **Date of Birth** | **Date of Trust** |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |

### ADDITIONAL CHILDREN FOR CHILDREN INSURANCE AGREEMENT (CIA) RIDER *(include natural, legally adopted or step children)*

| Name *(Last, First, MI)* | Sex | Relationship to Primary Insured | Date of Birth | Height & Weight | Age |
|---|---|---|---|---|---|
| 1. | ☐ M ☐ F | Child | | - | |
| 2. | ☐ M ☐ F | Child | | - | |
| 3. | ☐ M ☐ F | Child | | - | |
| 4. | ☐ M ☐ F | Child | | - | |

### ADDITIONAL HEALTH INFORMATION ON PROPOSED INSUREDS/PAYOR AND CHILDREN

| Insured's Name: | Medical Condition | Medications | Dates | Doctor's Name, Address, Telephone # |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

**Proposed Insured Signature** | **Signature of Second Insured, Other Insured or Payor** | **Date**

**Proposed Insured's previous address if moved within 2 years:**

### ILLUSTRATION CERTIFICATION AND ACKNOWLEDGMENT

***(Only to be completed for policies with no illustration, for specific states and participating plans of insurance)***

☐ I certify that a life insurance policy illustration(s) was not used during the sale of this life insurance policy.

☐ I certify that the policy(ies) applied for is other than as illustrated by me.

☐ I certify that a proposal was shown on a computer screen, but no hard copy(ies) was furnished.

**Agent's Signature** | **Date**

### APPLICANT'S ACKNOWLEDGMENT

I acknowledge that a life insurance policy illustration(s) was not given to me at the time my application was written. I further understand that I will receive an illustration(s) at or before the time a policy(ies) is delivered to me.

**Applicant's Signature** | **Date**

## – APPLICATION ADDENDUM –

Complete if additional insureds are to be covered **for Non-Simplified Individual Insurance only.** Please note **this addendum may only be used if the owner of all additional policies is the same person and is the owner listed under section 3 of this application.** If you wish to list different owners, or want additional riders, or want different dividend options this addendum cannot be used; an individual application will need to be submitted. Each insured under this addendum must answer all questions, provide details to yes answered questions listed in sections 3,4,7,8, 9A, 9B,10,11 and complete the financial section if applicable. ***(Refer to page 9 for all additional insureds to sign and date this addendum).***

**Additional Proposed Insureds will have same owner, plan and mode of payment.**

| **1. Name of Additional Proposed Insured** | Relationship to Owner | Date of Birth *Month Day Year* | Sex ☐M ☐F | Age | APL ☐Yes ☐No |
|---|---|---|---|---|---|
| Place of Birth | Social Security #/TIN # – – | Height & Weight _____ ft. _____ in. _____ lbs. | Marital Status ☐ Married ☐ Single | | |
| Amount of Insurance $ | Beneficiary Name, Address and Telephone # | Social Security #/TIN # | Age | Date of Birth *Month Day Year* | Relationship to Proposed Ins. |
| Premium Amount $ | WP ☐Y ☐N | ADB ☐Y ☐N Amt. | Employer & Address | Occupation | Monthly Income $ |
| Actively at Work ☐Yes ☐No | Proposed Insured Address if different from Owner's: | Telephone Numbers Home: | Other: | | |

| **2. Name of Additional Proposed Insured** | Relationship to Owner | Date of Birth *Month Day Year* | Sex ☐M ☐F | Age | APL ☐Yes ☐No |
|---|---|---|---|---|---|
| Place of Birth | Social Security #/TIN # – – | Height & Weight _____ ft. _____ in. _____ lbs. | Marital Status ☐ Married ☐ Single | | |
| Amount of Insurance $ | Beneficiary Name, Address and Telephone # | Social Security #/TIN # | Age | Date of Birth *Month Day Year* | Relationship to Proposed Ins. |
| Premium Amount $ | WP ☐Y ☐N | ADB ☐Y ☐N Amt. | Employer & Address | Occupation | Monthly Income $ |
| Actively at Work ☐Yes ☐No | Proposed Insured Address if different from Owner's: | Telephone Numbers Home: | Other: | | |

| **3. Name of Additional Proposed Insured** | Relationship to Owner | Date of Birth *Month Day Year* | Sex ☐M ☐F | Age | APL ☐Yes ☐No |
|---|---|---|---|---|---|
| Place of Birth | Social Security #/TIN # – – | Height & Weight _____ ft. _____ in. _____ lbs. | Marital Status ☐ Married ☐ Single | | |
| Amount of Insurance $ | Beneficiary Name, Address and Telephone # | Social Security #/TIN # | Age | Date of Birth *Month Day Year* | Relationship to Proposed Ins. |
| Premium Amount $ | WP ☐Y ☐N | ADB ☐Y ☐N Amt. | Employer & Address | Occupation | Monthly Income $ |
| Actively at Work ☐Yes ☐No | Proposed Insured Address if different from Owner's: | Telephone Numbers Home: | Other: | | |

| **4. Name of Additional Proposed Insured** | Relationship to Owner | Date of Birth *Month Day Year* | Sex ☐M ☐F | Age | APL ☐Yes ☐No |
|---|---|---|---|---|---|
| Place of Birth | Social Security #/TIN # – – | Height & Weight _____ ft. _____ in. _____ lbs. | Marital Status ☐ Married ☐ Single | | |
| Amount of Insurance $ | Beneficiary Name, Address and Telephone # | Social Security #/TIN # | Age | Date of Birth *Month Day Year* | Relationship to Proposed Ins. |
| Premium Amount $ | WP ☐Y ☐N | ADB ☐Y ☐N Amt. | Employer & Address | Occupation | Monthly Income $ |
| Actively at Work ☐Yes ☐No | Proposed Insured Address if different from Owner's: | Telephone Numbers Home: | Other: | | |

## – ACKNOWLEDGEMENTS –

To the best of my knowledge and belief, the statements in this application are complete and true. It is understood that if any statement is a material misrepresentation, coverage may be contested as a result. This application and any supplement shall form the basis for and become part of any policy issued. When the Company gives a Conditional Receipt coverage will start as shown in that form, provided the Company approves the application without any modification as to plan, amount or premium. If the application is approved with any such modification the insurance will not take effect until the policy has been delivered to and accepted by me and will not take effect if there has been a change in my health as stated in the application.

**The agent or tele-inteviewer has no authority to waive the answer to any question in or to modify the application.**

**Corrections and Amendments to be Accepted by Owner on Delivery of Contract.**

### CONSUMER REPORT AUTHORIZATION

I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

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### MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formally known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

### MIB REPORTING AUTHORIZATION

I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

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***Continued on the next page for additional Proposed Insureds***

## BOSTON MUTUAL LIFE INSURANCE COMPANY
## AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION

***(This authorization complies with the HIPAA Privacy Rule)***

I authorize any health plan, insurer, physician, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, services, or payment to the Proposed Insured/s, or on their behalf, as well as the MIB, Inc. *(formally known as the Medical Information Bureau, Inc.)* and other medical information providers, to disclose the entire medical record and any other Protected Health Information concerning such person to the Boston Mutual Life Insurance Company (BML), its employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. The Protected Health Information is being disclosed so that BML may: 1) underwrite/assess an applicant's eligibility for coverage, 2) obtain reinsurance, 3) pay claims and, 4) conduct other legally permissible activities related to the coverage applied for by this individual. This authorization shall remain inforce for 24 months following the date of my signature below. A copy of this authorization is as valid as the original. I understand that: I or my authorized representative have the right to revoke this authorization at any time by sending a written request for revocation. Revoking or failing to sign this Authorization may impair BML's ability to process this application; a revocation is not effective to the extent that the Authorization has been relied on for the above listed uses; any information disclosed pursuant to this authorization may be redisclosed and redisclosed information may no longer be covered by federal rules governing privacy or health information. I acknowledge that I have received a copy of BML's Notice of Privacy Practices. I have read this Authorization and understand that I or my authorized representative can receive a copy of it.

### • DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, hereby, designate the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative. This designation shall remain inforce for a period of 12 months following my date of death.

**"Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law."**

**NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.**

**NOTE: The agent is required to leave with you an original copy of written or printed communications used for presentation of the policy to you.**

**1.**

| | | |
|---|---|---|
| | | |
| **Application Signed at** ***(City, State)*** | **Signature of Additional Proposed Insured** ***(Parent or Guardian must sign if proposed insured is under age 15)*** | **Date** |

**Name, Address and Tele.# of Secondary Addressee**

**2.**

| | | |
|---|---|---|
| | | |
| **Application Signed at** ***(City, State)*** | **Signature of Additional Proposed Insured** ***(Parent or Guardian must sign if proposed insured is under age 15)*** | **Date** |

**Name, Address and Tele.# of Secondary Addressee**

**3.**

| | | |
|---|---|---|
| | | |
| **Application Signed at** ***(City, State)*** | **Signature of Additional Proposed Insured** ***(Parent or Guardian must sign if proposed insured is under age 15)*** | **Date** |

**Name, Address and Tele.# of Secondary Addressee**

**4.**

| | | |
|---|---|---|
| | | |
| **Application Signed at** ***(City, State)*** | **Signature of Additional Proposed Insured** ***(Parent or Guardian must sign if proposed insured is under age 15)*** | **Date** |

**Name, Address and Tele.# of Secondary Addressee**

## BOSTON MUTUAL LIFE INSURANCE COMPANY CONDITIONAL RECEIPT FOR LIFE INSURANCE

UNLESS EACH AND EVERY CONDITION SPECIFIED BELOW is fulfilled exactly, no insurance will become effective prior to policy delivery, and the Company's liability will be limited to the refund of the payment for which this receipt is given. No Agent of the Company is authorized to alter or waive any such conditions.

Received from _____ the sum of $ _____ being payment on account of an application for life insurance to the Boston Mutual Life Insurance Company, which application bears the same date.

The insurance applied for shall take effect (subject to the Limit of Liability) on the later of the date of the completed application or the last of any medical examinations or tests required by the Company, provided that the following conditions are fulfilled:

1. This payment must be equal to one monthly premium for the policy(s) applied for.
2. On the date the insurance is to be effective the Proposed Insured(s) must be acceptable to the Company at the standard premium rate for the plan and amount requested.

LIMIT OF LIABILITY: Any life insurance, including any accidental death benefits, effective under this Conditional Receipt shall not exceed $100,000 on any person. This limit includes any such benefits already in force in the Company. Any premium paid in excess of such maximum liabilities shall create no additional liability on the part of the Company. This receipt shall be void in event of dishonor of any check or draft given for said payment and shall automatically become void at the end of sixty days after the date here of. This limit of liability shall be applicable to the insurance applied for under this and any other pending application. If the application is not approved within sixty days, the application file will be closed and you will be so notified. If you do not receive a contract or refund within sixty days please notify the Company. Give the amount paid, date of payment and name of the person to whom paid.

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY.**
**DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

| Agent | | Date | |
|---|---|---|---|

***Please leave this page with the Proposed Insured***

| | | | |
|---|---|---|---|
| ***SERFF Tracking #:*** | *BSTN-128730545* | ***State Tracking #:*** | ***Company Tracking #:*** *IND-12-009* |

| | | | |
|---|---|---|---|
| ***State:*** | *Arkansas* | ***Filing Company:*** | *Boston Mutual Life Insurance Company* |
| ***TOI/Sub-TOI:*** | *L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life* | | |
| ***Product Name:*** | *General Agency Simplified Underwriting Application* | | |
| ***Project Name/Number:*** | *GA SI Underwriting Application /IND-12-009* | | |

# Supporting Document Schedules

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Flesch Certification | | |
| Comments: | Please find the Flesch Certification attached. | | |
| Attachment(s): | | | |
| NB1 SF SD 3 12 read cert.pdf | | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Cover Letter | | |
| Comments: | Please find the Cover Letter attached. | | |
| Attachment(s): | | | |
| FLTR-STD (4).pdf | | | |

| | | **Item Status:** | **Status Date:** |
|---|---|---|---|
| Satisfied - Item: | Statement of Variability | | |
| Comments: | | | |
| Attachment(s): | | | |
| statement of variability LIFE.pdf | | | |

120 ROYALL ST * CANTON, MASSACHUSETTS * TEL (781) 770 0378 * FAX (781) 770 0490

BOSTON MUTUAL
LIFE INSURANCE COMPANY

I certify to the best of my knowledge and belief that these forms are in compliance with the NAIC Model Act regarding Simplified and Readable Life Insurance Policies.

I also certify that the Flesch scores for the form(s) contained in this submission are as indicated below.

| FORM # | FLESCH SCORE |
|---|---|
| SF/SD 3/12 | 68.2 |

I also certify that these forms are printed in not less than 10 point type, one point leading.

Peggy Schwartz
Product Filing Manager

Date: October 16, 2012

120 ROYALL STREET • CANTON, MASSACHUSETTS 02021 • (781) 770-0423 • FAX (781) 770-0490


*Peggy Schwartz, FLMI, ALHC, AIRC*
*Product Filing Manager*

October 16, 2012

**VIA SERFF**

RE: Boston Mutual Life Insurance Company
NAIC # 61476 FEIN #04-1106240
Individual Life Insurance Application Form:
Form #: SF/SD 3/12

Company Filing No. IND-12-009

We are submitting for approval the above application form. This is a new form and does not replace any existing form.

This is a simplified underwriting application which will be used by licensed independent agents and brokers in the individual life insurance market. It will be used to apply for both whole life and term life coverage under policy forms approved in your state.

The form does not contain any unusual or controversial items from the standpoint of normal company or industry standards. The form is in final print, 10-point type. It meets the minimum readability requirements of this state and a certification is included with this filing. To the best of our knowledge and belief, this submittal complies with the laws and regulations of your state.

DOMICILLIARY APPROVAL: This form was filed concurrently in Massachusetts our state of domicile.

Please call me if you have any questions regarding this filing.

Sincerely;

Peggy Schwartz

Peggy Schwartz, FLMI, ALHC, AIRC
Product Filing Manager
781 770 0423
Fax: 781 770 0490
Marguerite_schwartz@bostonmutual.com

# BOSTON MUTUAL LIFE INSURANCE COMPANY
# EXPLANATION OF VARIABLES
# INDIVIDUAL LIFE SIMPLIFED APPLICATION

## GENERAL VARIABLES

Unless otherwise noted, all bracketed text in the forms and within this statement of variability is variable only to the extent that it may be included or omitted according to a policyholder's plan of insurance.

Titles of specific Acts or Laws may be modified as appropriate. Letters and numbers as they appear in a list, punctuation or words such as "and" or "or" will be included or omitted as needed in order to make the statement or list read correctly.

## SPECIFIC VARIABLES

**On page 1:**

"I am actively at work at least **[8-40]** hours a week"

**This statement can be customized to be read with the number of hours which the employer uses to determine "full-time" or "part-time" work as needed.**

[Have your or your spouse used tobacco or nicotine products in the last 12 months?]

**The above question will be removed or included depending on whether tobacco rates or non-tobacco rates are used.**

[During the past six months, has your spouse been seen or treated including testing in a hospital of any other medical facility excluding physicians' offices for routine medical care?]

**The above question will be removed or included depending on whether or not spouse/partner coverage is included.**

Life Insurance Options: 1-3 (select only one option)

| Option 1 – Life Insurance | Option 2 – Life Insurance |
|---|---|
| Employee Face Amount [$10,000 - $100,000] | [Spouse Face Amount [$10,000 - $50,000]] |
| Weekly premium **[ $2-$5]** | Weekly premium **[ $2-$5]** |
| [Children's Insurance Rider (CIR) [$5,000-$15,000]] | [Children's Insurance Rider (CIR) [$5,000-$15,000]] |
| Weekly premium **[ $2-$5]** | Weekly premium **[ $2-$5** |
| Total [Weekly, Semi-monthly or Monthly] Premium **[$2-$50]** | Total [Weekly, Semi-monthly or Monthly] Premium **[$2-$50]** |

I elect Option_____. Total [Weekly, Semi-monthly or Monthly] Premium:_____

**The spouse/partner and children's coverage is optional, as is the face amount of each, and the face amount of the Employee/Primary Insured's coverage. Under each Option (1 or 2) a different flat face amount will be offered for the primary insured's choice. Premium ranges are shown for each coverage and for the total premium which can be paid weekly, semi-monthly or monthly.**

Page 2 & 3 - Fraud warning list

**The list has been bracketed to allow for required updates/changes to the fraud warning to keep them current with state regulations. An example of this type of change is the Maryland fraud warning which will change effective 1/1/13 with a caveat that the revised wording cannot be used until that date.**